APPENDIX E - PLAN OF CARE

APPENDIX E-1

Assessment of level of care is done in the Resource Center separate from and completely independent of the CMO. Information gathered during the level of care assessment is forwarded to the economic support unit and to the CMO when the individual enrolls in Family Care. The CMO interdisciplinary case management team, which includes the consumer, uses that information in completing a comprehensive assessment of the consumer's service needs. The team then develops a plan of care tailored to the individual's needs and preferences. This care planning is the essence of effectively managing care.

Each CMO maintains its own plan of care database to meet internal needs for information on services authorization and utilization. From those local databases, each CMO is required to report the identical HIPPA-compliant data elements electronically to the Department in an all-purpose ASCII format. This gives the state the flexibility to input, store and manipulate data in its own plan of care database, which will cross-feed into several other Family Care databases in our data warehouse, providing invaluable information for QA/QI and research. The rationale for not providing or requiring a uniform software product is that each CMO is part of a larger county data system and as such they use a variety of software already in place for internal tracking of costs (including IBNR) and payment of bills.

The Department will provide a model plan of care form (see attached). Each CMO may either use the model form or submit a substitute form that again includes identical data elements in a HIPPA-compliant format for approval by the state. The CMO will be required to retain completed and signed paper plan of care forms for each enrollee for three years. The rationale for permitting each CMO to modify the plan of care form is that it will be easier to input data into the local plan of care database if the paper forms are arranged in a manner that corresponds to the local database structure.

Of course, all paper and electronic data will have the usual security and confidentiality precautions and electronic data will be routinely backed up. This model of local flexibility in data collection and storage tools along with well defined data elements for data submission has been used successfully by the Department for collecting information about Resource Centers I&A services.

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

_X_ Registered nurse, licensed to practice in the State

___ Licensed practical or vocational nurse, acting within the scope of practice under State law

___ Physician (M.D. or D.O.) licensed to practice in the State

X Social Worker ~~(qualifications attached to this Appendix)~~ (Certified to practice in Wisconsin)

X Case Manager Case managers are required to have a minimum of a four-year bachelor's degree in the social services area (e.g. social work, rehabilitation psychology, etc.). The case manager must also have knowledge of community alternatives for the target populations served by the CMO and the full range of long term care resources. Additionally, the case manager must have specialized knowledge of the conditions of the target populations served by the CMO.

___ Other (specify):

_____

2. Copies of written plans of care will be maintained. Specify each location where copies of the current plans of care for each waiver participant will be maintained.

___ At the Medicaid agency central office

___ At the Medicaid agency county/regional offices

X By case managers

___ By the agency specified in Appendix A

___ By consumers

___ Other (specify):

_____

3. Copies of written plans of care will be maintained for a minimum period of 3 years after the waiver participant leaves the waiver program. Specify the location where copies of the plans of care will be maintained.

____ At the Medicaid agency central office

____ At the Medicaid agency county/regional office (in the case record)

X By case managers

____ By the agency specified in Appendix A

____ By consumers

____ Other (specify):

_____

4. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. Reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability.

   The minimum schedule under which these reviews will occur (not to exceed 12 months) is:

   ___ Every 3 months

   ___ Every 6 months **or** sooner if services are added or deleted.

   ___ Every 12 months

   _X_ Other (specify):

   The member and the care management team shall review and update the member's plan of care periodically (at a minimum of every 12 months) based on the findings of the periodic reevaluation using the functional screen and as the member's preferences, situation and condition changes or the plan of care fails to accomplish the planned outcomes.

APPENDIX E-2

A. MEDICAID AGENCY APPROVAL

1. The following is a description of the process by which the plan of care is made subject to the approval of the MEDICAID AGENCY**:**

Plan of care reviews will be conducted on an ongoing basis and will be carried out concurrently as the CMO develops and implements the member's service plan. It is anticipated that for each CMO a sample of new and continuing CMO members will be selected at least every six months. Sampling will be done on two groups of members, a 5% random sample of new and continuing members, and at least 5% of all individuals who are selected based on pre-established targeting criteria. The second group will consist of targeted cases where the functional eligibility screen or some other tool will be used to identify members that may be at a higher risk for health, safety and welfare issues. The combined sample size will be not less than 10% of the total population under review.

Documentation of the plan of care for each individual in the sample is made available to the DHFS, OSF, CDSD designated reviewers, either on-site at the Care Management Organization or off-site at the Medicaid agency. Reviewers knowledgeable about the Family Care target groups as well as waiver services, eligibility requirements, and the service delivery system, which provides supports for persons with developmental and physical disabilities and persons who are elderly, review plans of care. The POC may also be reviewed in consultation with other professionals within the DHFS including nurse consultants, therapy consultants and others who have knowledge of services and needs of persons in the target group.

When a plan of care identifies and addresses all of the member's assessed needs adequately, the care plan is considered approved. If the reviewer finds that services in a plan of care do not agree with the member's disabilities and needs in critical areas, or if basic member needs are overlooked in the assessment, an immediate referral will be made to the Department and the CMO is contacted. If after further investigation it is determined that the effect on the member is serious, the CMO will be directed to take immediate corrective action to ensure that the essential needs of the member are adequately addressed. In this circumstance, the plan of care will not be approved until identified problems are corrected. The DHFS will track and trend review findings and provide a periodic report to the CMO. If a CMO is found to have an unfavorable trend towards non-approval of plans of care, the rate of review may be intensified.

2. Specify how you will review plans of care (e.g., frequency, size of sample) **See Attachment 18. State Quality Strategy for a more detailed description of the review process described here.**

Service plan reviews will look at the CMO's capacity for supporting members to meet their service needs while respecting their individual preferences and desired outcomes. Two types of review will be conducted. First, reviews of plans of care of a random sample of not less than 5% of all new waiver participants will be conducted. Second, a targeted review of service plans will be conducted on subgroups of CMO members, such as any member who relocates from an institution into the community. Reviewers will examine available information about services, supports, time frames, staff responsible for service provision, and documentation of the member's preferences and needs. The purpose of the review is to determine how well the CMO is using the assessment and planning process to coordinate supports for the individual and whether or not the CMO is writing service plan goals that reflect the individual's stated desires and preferences.

B. CONTENT AND COPY OF PLAN OF CARE

The plan of care will contain, at a minimum, the type of medical and other services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.

X A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

Attachment E.B. Wisconsin DHFS Family Care Individual Service Plan